MASSACHUSETTS GENERAL HOSPITAL

MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION

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Dear Colleagues, Patients and Friends:

On Jan. 16, 2009, the Massachusetts Department of Public Health informed Massachusetts General Hospital that we had been identified as a high-mortality statistical outlier on the 2007 Massachusetts Data Analysis Center (Mass-DAC) report for percutaneous coronary intervention (PCI). We had first become aware in May 2008 of these higher-than-expected 2007 mortality figures from preliminary Mass-DAC reports and from our own internal quality assurance activities. At that time we analyzed the relevant cases and outcomes in great detail. This review determined that our interventional group was performing PCI in an excess number of critically ill patients for whom the intervention had a relatively low likelihood of changing the ultimate outcome.

We concluded that approximately three-quarters of the deaths after PCI in 2007 were a result of the patients' pre-existing conditions. Examples of these patient deaths are described in our report to the DPH. In mid-2008, we implemented changes in patient selection for PCI and subsequently saw a significant decrease in our mortality rate. On Jan. 20, 2009, we presented to the DPH detailed information about our review of the 2007 post-PCI deaths. An independent outside reviewer evaluated these same cases and agreed with our assessment.

The DPH will soon be releasing the statewide 2007 PCI mortality data on its website. In conjunction with the posting of the data and the questions that it may raise, we wanted to make available to the public the information we had provided to the DPH. In addition to offering an important context in which to view the data, this report may help the public understand our perspectives on this matter and get a better sense of the complexities involved in making decisions about the use of PCI for very ill patients.

At the request of DPH we will have another external review body evaluate data from our Catheterization Laboratory to ensure we were correct in determining that the higher-than-average mortality rate was associated with patient selection rather than quality of care. While we believe our current assessment will be validated, we also feel strongly that the safety of patients is paramount and that the importance of getting this assessment right cannot be overstated. The patient selection issue also raises important public policy questions regarding where to draw the line in determining which critically ill patients should undergo PCI. Indeed, every PCI-capable hospital and every interventional cardiologist struggles with this complex decision on a recurrent basis. We look forward to contributing to this important dialogue.

Sincerely,

Peter L. Slavin, MD

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